APPLICATION FOR REGISTRATION UNDER THE PROFESSIONAL CORPORATION ACT

State Form 50160 (R / 7-02)
Approved by State Board of Accounts, 2002

HEALTH PROFESSIONS BUREAU
402 West Washington Street, Room W041
Indianapolis, Indiana 46204
(317) 232-2960
www.in.gov/hpb

FOR OFFICIAL USE ONLY	
Application fee	Date fee paid
Receipt number	

PLEASE PRINT OR TYPE

Name of corporation

Principal office address (*number and street or rural route, city, state, ZiP code*)

Telephone number (*daytime*)	Email address	Website address

Check one corporation type:

- ☐ Acupuncture
- ☐ Athletic Training
- ☐ Audiology
- ☐ Chiropractic
- ☐ Dental
- ☐ Dental Hygiene
- ☐ Dietetics
- ☐ Environmental Health
- ☐ Health Facility Administration
- ☐ Hearing Aid Dealer
- ☐ Hypnotism
- ☐ Marriage and Family Therapy
- ☐ Medical
- ☐ Mental Health Counseling
- ☐ Nursing
- ☐ Occupational Therapy
- ☐ Occupational Therapy Assistant
- ☐ Optometry
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physical Therapy Assistant
- ☐ Physician Assistant
- ☐ Podiatry
- ☐ Psychology
- ☐ Respiratory Care
- ☐ Social Work
- ☐ Speech-Language Pathology
- ☐ Veterinary
- ☐ Multidisciplinary

NOTE: *Complete and return this application with a check in the amount of twenty-five dollars ($25.00) made payable to the Health Professions Bureau. A certificate of registration will be issued from this office which you must file with the Office of the Secretary of State of Indiana, State House, Indianapolis, Indiana.* ***THIS APPLICATION DOES NOT CONSTITUTE A CERTIFICATE AND CANNOT BE USED FOR FILING WITH THE INDIANA SECRETARY OF STATE.***

PLEASE NOTE: THE REGISTRATION PROCESS WILL NOT BE COMPLETE UNTIL THE HEALTH PROFESSIONS BUREAU RECEIVES A COPY OF THE ARTICLES OF INCORPORATION CERTIFIED BY THE OFFICE OF THE SECRETARY OF STATE. *We suggest that you submit an extra copy of the Articles of Incorporation to the Office of the Secretary of State for this purpose.*

Notification shall be given to the Health Professions Bureau within thirty (30) days after a change of business address of the Corporation and the admission or withdrawal of a shareholder. Notification shall include the names and addresses of both the transferrer and transferee shareholders. In addition, a certified copy of all amendments to the Articles of Incorporation must be submitted to the Health Professions Bureau.

List name, address, and licensure data for each shareholder, officer and director of the proposed corporation. Check the appropriate box in the last column. Attach additional 8 1/2" x 11" sheet if necessary.

NAME AND ADDRESS	PROFESSION	INDIANA LICENSE NUMBER	OTHER STATE LICENSE (*State and License #*)	STATUS
				☐ Shareholder ☐ Officer ☐ Director
				☐ Shareholder ☐ Officer ☐ Director
				☐ Shareholder ☐ Officer ☐ Director
				☐ Shareholder ☐ Officer ☐ Director
				☐ Shareholder ☐ Officer ☐ Director

(*Continued on the reverse side*)

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				☐ Shareholder ☐ Officer ☐ Director
				☐ Shareholder ☐ Officer ☐ Director
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The undersigned hereby make(s) application for a certificate to establish and operate a professional corporation. This application is to show that each proposed shareholder and director of the corporation is a reputable and responsible health care professional as required by IC 23-1.5-1-8 and IC 23-1.5-2-3. The corporation further agrees to comply with IC 23-1.5, and agrees that the corporation will be organized in compliance with the statutes and regulations of the relevant licensing authorities. I / We hereby swear or affirm under the penalties of perjury that the statements made in this application are true, complete, and correct. If this application is signed by an incorporator who is not a shareholder, the incorporator further certifies that the incorporator has been duly granted the authority by the shareholders and directors of the proposed corporation to sign this application.

Signature of applicant	Signature of applicant
Printed name of applicant	Printed name of applicant
☐ Incorporator ☐ Shareholder	☐ Incorporator ☐ Shareholder
Date signed (*month, day, year*)	Date signed (*month, day, year*)
Signature of applicant	Signature of applicant
Printed name of applicant	Printed name of applicant
☐ Incorporator ☐ Shareholder	☐ Incorporator ☐ Shareholder
Date signed (*month, day, year*)	Date signed (*month, day, year*)

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VERIFICATION OF STATE LICENSURE FOR INDIANA PROFESSIONAL CORPORATION REGISTRATION APPLICATION

YOU DO NOT NEED TO COMPLETE THIS FORM IF YOU ARE LICENSED TO PRACTICE IN INDIANA.

Privacy Notice: This state agency is requesting disclosure of your Social Security number, under IC 4-1-8-1. This form cannot be processed without it.

INSTRUCTIONS FOR PRACTITIONERS: Please type or print. Complete the top section. Make copies and send to each state in which you hold a license. Have the state(s) send this form directly to the Health Professions Bureau. This form is to be used only for verification of licensure status for the purpose of registering a professional corporation. It cannot be used for applying for verification when applying for a license. The Health Professions Bureau will accept the standard state verification form provided by another state in lieu of this form.

Name (*last, first, middle*)		
Type of health profession license held		
Social Security number		
License number	Date of issuance (*month, day, year*)	Date of birth (*month, day, year*)
I hereby authorize the State of _____, to furnish to the Indiana Health Professions Bureau the information below.		
Signature of practitioner		

Practitioner: Do not write below this line.		
License number	Date of issuance	Profession
License is current and in good standing? ☐ Yes ☐ No	Expiration date	Any derogatory information? ☐ Yes ☐ No
IF LICENSE HAS BEEN ENCUMBERED IN ANY WAY, PLEASE PROVIDE CERTIFIED COPIES OF ALL RELATED DOCUMENTS. PLEASE AFFIX BOARD SEAL.		
Form completed by:		
Printed name		Title
Signature		Date (*month, day, year*)
State Board name		